BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

PERRY A. RUSSELL Claimant	)	
VS.	)	
BOARD OF COUNTY COMMISSIONERS OF CHAUTAUQUA COUNTY, KANSAS Respondent	)	Docket No. 1,024,403
AND	)	
KANSAS WORKERS RISK COOPERATIVE FOR COUNTIES Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Respondent and its insurance carrier (respondent) requested review of the December 7, 2007, Award entered by Administrative Law Judge Nelsonna Potts Barnes. The Board heard oral argument on March 4, 2008. Orvel Mason, of Arkansas City, Kansas, appeared for claimant. Jeffery R. Brewer, of Wichita, Kansas, appeared for respondent.

The Administrative Law Judge (ALJ) found that claimant's condition in July 2006 was a natural and probable consequence of his May 18, 2005, work injury. The ALJ found that respondent failed to meet its burden of proof that claimant suffered any preexisting functional impairment in accordance with the AMA *Guides*,[1] and found that claimant had a 25 percent general body functional disability consistent with the opinion of Dr. Pedro Murati.

The Board has considered the record and adopted the stipulations listed in the Award.

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[1] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

ISSUES

Respondent requests review of the ALJ's findings concerning the nature and extent of claimant's disability. Specifically, respondent argues that it is undisputed that claimant had a preexisting injury in 1996 that resulted in back surgery at the L5-S1 level. Respondent argues that claimant's work injury of May 18, 2005, resulted in no additional permanent impairment, or if additional permanent impairment did occur as a result of that accident and injury, there was preexisting impairment for which respondent should not be liable to pay. Respondent states that Dr. Murati originally testified that claimant had a 25 percent permanent partial impairment to the body as a whole and assigned claimant a 10 percent preexisting impairment. Dr. Murati's testimony was taken a second time, at which time he testified that because claimant evidenced no changes or problems in his activities of day to day living before May 18, 2005, there would be no preexisting impairment. This testimony, respondent contends, is a contradiction of Dr. Murati's original deposition testimony and makes his opinion unpersuasive.

Respondent argues that Dr. Stein's testimony that claimant had no permanent partial impairment as a result of his May 18, 2005, injury and that any permanent partial impairment claimant has is a result of his preexisting injury is more credible than the testimony of Dr. Murati. Respondent also contends that claimant's aggravation in July 2006 was either a natural consequence of his preexisting condition or resulted from a new injury from claimant's subsequent work activities. In the alternative, respondent requests the Board find that claimant's permanent partial impairment should not exceed 17 percent, which was Dr. Murati's original opinion.

Claimant argues that respondent failed to establish that claimant had a preexisting impairment. Claimant further contends that the ALJ correctly concluded that Dr. Murati's rating opinion is the most credible in this case. Claimant is not seeking an award of work disability. Accordingly, the claimant requests the Board affirm the Award entered by the ALJ.

The issues for the Board's review are:

(1) What is the nature and extent of claimant's disability?

(2) Did respondent sustain its burden of proving that claimant had a preexisting impairment?

(3) Was claimant's exacerbation in July 2006 and subsequent surgery a direct result of his May 18, 2005, injury or, instead, either a natural consequence of his preexisting condition or the result of new injuries that occurred while claimant was working for subsequent employers?

FINDINGS OF FACT

Claimant injured his back in 1996 as a result of a horseback-riding incident. As a result, he underwent a discectomy at the level of L5-S1. After surgery, he was able to return to doing the things he did before the surgery. He was given no restrictions on his activities and was not given a permanent impairment rating. At the time, he was working at the Southeast Kansas Juvenile Detention Center, and he was able to return to performing his work without accommodations.

Claimant began working for respondent as a deputy in the Sheriff's Department on March 14, 2004. On January 14, 2005, he was appointed undersheriff. On May 18, 2005, claimant was on jail duty and was carrying a load of laundry up some stairs when he twisted and felt an excruciating pain in his low back and right leg. The low back pain was at the belt line, slightly on the right side. He reported the incident to the Sheriff and finished his shift by doing as little work as possible.

The next day, May 19, 2005, claimant was seen in the emergency room of the Sedan City Hospital, where he was seen by David Short, a physician's assistant. Mr. Short performed an examination of claimant wherein he noted that claimant's deep tendon reflexes were normal. Claimant was also evaluated by Dr. McDermott. He was released from the emergency room that day with prescriptions for Lortab and Flexeril. He was told to go home, keep ice on his back, avoid lifting more than a gallon of milk, and told to rest in bed with his legs elevated. Dr. McDermott saw claimant for a followup and ordered an MRI, after which he told claimant that he had a herniated disc at L5-S1. Claimant was off work for one week.

Dr. McDermott suggested that claimant be seen by a neurosurgeon, Dr. Frank Tomecek, Jr. Dr. Tomecek saw claimant one time, on June 6, 2005. Upon examination, he found that claimant had bilateral symmetric reflexes. He stated that claimant's lower extremity reflexes were diminished but were present. Dr. Tomecek reviewed the MRI of claimant's spine and noted that claimant had a recurrent disc herniation at L5-S1. Claimant told Dr. Tomecek that his right leg pain had been severe after the injury but had improved. Since claimant was not disabled or incapacitated and had returned to work full time, Dr. Tomecek did not recommend surgical intervention. Claimant, however, was under the impression that Dr. Tomecek was recommending surgery, and he asked to have a second opinion. Respondent scheduled him to be seen by Dr. Paul Stein.

Before being seen by Dr. Stein, claimant was terminated from his position as the undersheriff. As an undersheriff, he served at the pleasure of the sheriff, and his letter of termination gave no specific reason for his termination. Sheriff Frank Green testified that claimant was terminated for various incidents where he did not follow the policies and procedures of the Sheriff's Department. Claimant's termination was effective June 30, 2005.

Dr. Paul Stein is a board certified neurological surgeon who regularly performs independent medical examinations. He initially saw claimant on July 26, 2006. Upon examination, he found that claimant had no atrophy or fasciculations. Knee reflexes were present and symmetric. Claimant had a left ankle reflex, but Dr. Stein noted that claimant's right ankle reflex was absent. Dr. Stein found that claimant had tenderness around his right sacroiliac joint. He had no palpable lumbar muscular spasm. His lumbar range of motion was moderately restricted. Straight leg raising on the right caused some discomfort in the buttock and sacroiliac region. Dr. Stein agreed with Dr. Tomecek that claimant was not a candidate for surgery. He recommended epidural steroid injections and physical therapy. He also placed claimant on restrictions, recommending that claimant avoid lifting more than 40 pounds with a single lift up to twice a day, 30 pounds occasionally and 15 pounds frequently; avoid repetitive lifting from below knuckle height; no repetitive overhead activity; and no repetitive bending or twisting of the lower back. Claimant was advised to alternate sitting with standing and walking.

On November 7, 2005, claimant went to work for Cessna, where his job involved riveting parts on the tail cone of the Cessna Mustang. By the time claimant went to work for Cessna, he felt like he was in tolerable condition to be able to maintain a job as long as he was careful and did not try to lift much. The pain in his leg had subsided about a month before he started working for Cessna. When he would awaken in the mornings, he was stiff, but he would feel better after stretching and a hot shower. He worked at Cessna for three months and then left because he did not like the job. He also stated that the job caused him physical problems because it required him to stand on concrete in one place for about seven hours of an eight hour day. Claimant said his work at Cessna did not increase his back pain, but he also said that at the end of the day he would be stiff and sore.

When claimant left his job at Cessna, he started working for SEK Grain (SEK). At SEK, claimant drove a truck, a spray rig, and other farm equipment. Other times, he helped customers with orders, filled tanks, and loaded fertilizer. He was required to occasionally lift in the neighborhood of 40 to 45 pounds. He normally worked about 48 hours a week, 5 1/2 days a week. Claimant would go home at the end of the day with more pain in his back than he had at the beginning of the workday.

Claimant saw Dr. Stein a second time on April 19, 2006, for an impairment rating. Dr. Stein did not perform an examination of claimant on that date. At that time, Dr. Stein believed claimant was in the AMA *Guides* diagnosis related estimate (DRE) lumbosacral Category III and had a 10 percent whole person impairment. Based on the history given to Dr. Stein by claimant and his examination in July 2005, he believed that claimant's 10 percent permanent partial impairment was related to his original surgery. He opined that claimant would have been in the DRE lumbosacral Category III from the time of his 1996 surgery and, therefore, would have no additional impairment of function to the low back from his more recent injury. Dr. Stein related that AMA *Guides* require that once a claimant is in an impairment category for the lumbar spine, he is always in that category. Additional injury produces additional permanent impairment only if it moves a claimant to a new and

higher category, in which case the new impairment is the difference between the two categories.

Claimant asked that he not to be given restrictions on April 19, 2006. Dr. Stein stated that if not for this request, he would have recommended work restrictions that would have been less restrictive than those he gave in 2005.

Claimant stated that when he went to bed the evening of July 8, 2006, he had his normal feeling of stiffness and soreness. When he raised up to get out of bed on July 9, he felt the same excruciating pain in his low back and right leg that he had felt when he injured himself at respondent. He could not put his foot on the floor, and the pain radiated through his buttocks, down the side of his right thigh, and into his calf. He hobbled to the bathroom and took a pain pill and got an ice pack. The next day he went to see a chiropractor, who suggested he see a medical doctor. Claimant went to see Dr. McDermott. Upon examination of claimant, Dr. McDermott found that his deep tendon reflexes were one plus/four plus, which meant that his patellar reflexes at the knees and the Achilles reflexes over the Achilles tendon were equal. Dr. McDermott gave claimant a steroid cortisone shot to try to relieve the pain and made arrangements for him to be seen by Dr. David Malone, a neurosurgeon.

Claimant was initially seen by Dr. Malone on July 12, 2006. He gave a history of a disk herniation with surgery in 1996 with a good outcome for nine years until he injured his low back carrying baskets of laundry up some stairs. Claimant's pain worsened on July 9 and radiated into his posterior thigh and calf with numbness in his right foot. Since then, he had been on narcotic medication and had chiropractic therapy and acupuncture with no improvement. The majority of his pain was in his leg with very little low back pain. An MRI had been taken on July 11 which showed that there was an epidural fibrosis around the right S1 nerve root. In comparing the May 24, 2005, MRI scan to the one obtained on July 11, 2006, Dr. Malone noted that both showed a ruptured disc at L5-S1 but the rupture was significantly larger on the later scan. Dr. Malone diagnosed claimant with sciatica secondary to disk herniation and recommended a microdiscectomy. Claimant underwent right L5-S1 microdiscectomy on July 18, 2006. He was released from treatment by Dr. Malone on October 13, 2006, with a work release and no restrictions.

Dr. Pedro Murati, a certified independent medical examiner who is also board certified in electrodiagnostic medicine and rehabilitation and physical medicine, examined claimant on February 21, 2007, at the request of claimant's attorney. He took a history of claimant's injury, complaints and treatment; performed a physical examination of claimant; and reviewed claimant's medical records. At that time, claimant was complaining of a dull, aching low back pain. His back got tired and tight at the end of the day. Occasionally, his right buttock and leg went numb. He experienced hip pain that worsened with movement.

Upon examination, Dr. Murati noted that claimant's right ankle reflex was absent. He had a loss of sensation along the right L5 dermatome. Muscle strength was normal. There was no atrophy of the lower extremities. Dr. Murati's examination of claimant's back

revealed the L5 spinous process to be tender to palpation, with an increased tone on the right. Straight leg raise was 70 degrees on the right. Claimant had an asymmetric pelvis, but everything else was normal.

Dr. Murati diagnosed claimant with low back pain secondary to radiculopathy. He opined that, within a reasonable medical probability, claimant's current diagnosis is a direct result of his work-related accident on May 18, 2005. Dr. Murati placed claimant in the Lumbosacral DRE Category V for a 25 percent whole person impairment. He concluded claimant had a 10 percent preexisting impairment and that claimant had a 17 percent whole person impairment based on the May 18, 2005, accident.

Dr. Murati rated claimant as having a 10 percent preexisting impairment because he had a disk herniation in 1996 with surgery. He had no records of the previous back surgery but only a history from claimant. He did not know at what level the preexisting surgery was performed. He did not know if claimant had any restrictions from the previous injury or whether he had a previous impairment rating. He said his 10 percent preexisting rating was substantiated in part by the MRI taken on May 25, 2005, which noted "moderate postsurgical fibrosis seen right paracentrally."[2] He concluded there was objective evidence from that MRI to substantiate the 10 percent preexisting impairment.

Dr. Stein saw claimant again on June 20, 2007, at the request of respondent, to re-evaluate his condition. After re-evaluating claimant, Dr. Stein was still of the opinion that he was in DRE Category III of the AMA *Guides*, which is a 10 percent whole body impairment. Dr. Stein said that claimant's condition was better after his second surgery; however, his impairment remained the same. He continued to believe that claimant's 10 percent impairment preexisted his work injury in May 2005.

Dr. Stein did not have any records of claimant that predate May 24, 2005, so he did not have any records from claimant's 1996 surgery. He agreed that it is preferable to have the medical records for consideration of prior impairment. Dr. Stein agreed that radiculopathy from a L5-S1 nerve root would typically go down the back of the leg. Leg pain in the front of the leg would not be considered radiculopathy from an L5-S1 disc. The only thing he was told by claimant concerning leg pain was that he had right leg pain. He did not indicate the location of that pain.

In explaining why he concluded that claimant had radiculopathy from his original 1996 injury, Dr. Stein stated:

> The fact that it resolved after surgery with surgery at L5-S1 certainly was part of that, but he had when I examined him an absent ankle reflex, which would be consistent with L5-S1. His right ankle reflex was absent, the left one was intact. His current MRI scan in 2005 showed no evidence of compression of the S1 nerve root, so I, therefore, felt that it was an appropriate, within a reasonable degree of

[2] Murati Depo. (May 2, 2007), at 16, Ex. 2 at 1.

> medical probability, assumption that the ankle reflex was from the original injury and surgery. That would have put him in Category III at that time.[3]

He did not discuss with claimant whether he had numbness and tingling in the right lower extremity before the 1996 surgery. In July 2005, Dr. Stein had found no evidence of compression of the nerve root. There was some foraminal narrowing, but not enough to be significant and compressive on the nerve. There was no herniated disc. The absent ankle reflex was not explained by any kind of nerve impingement.

When Dr. Stein saw claimant on June 20, 2007, he gave him permanent restrictions, recommending that claimant avoid repetitive bending and twisting of the lower back, avoid lifting more than 50 pounds with any single lift, 40 pounds occasionally but not continuously, and 25 pound frequently but not continuously. Lifting should be done with good body mechanics. Dr. Stein reviewed a task list prepared by Doug Lindahl. Of the 22 tasks on that list, Dr. Stein opined that claimant would be unable to perform 4 for a task loss of 18 percent.

Although Dr. Stein opined that claimant's recurrent disc was a consequence of his original injury, he believed that the injury in May 2005 contributed at least in some fashion to the recurrent disc herniation that claimant suffered.

After the deposition testimony of Drs. McDermott, Tomecek, and Stein, claimant took Dr. Murati's deposition a second time to clarify some issues in light of additional medical records. At this second deposition, Dr. Murati testified that most people have back surgery for radiculopathy, and he assumed that was the case with claimant's original surgery. With that assumption, Dr. Murati had believed a 10 percent preexisting impairment was reasonable. He had assumed claimant had preexisting radiculopathy before his current injury and that the first injury produced impairment, meaning that he had limitations in his activities of daily living. If any of those assumptions were wrong, he testified it could mean that claimant had less impairment or no impairment at all. He stated that the AMA *Guides* define radiculopathy as requiring atrophy or loss of ankle reflexes, and a person should have significant signs of radiculopathy before he or she can be categorized in DRE Category III, which gives a 10 percent impairment.

Dr. Murati did not have the records of claimant's treatment for the 1996 injury at the time he examined him in February 2007. At that time, claimant told Dr. Murati that he had returned to work with no restrictions and no impairment rating after his 1996 surgery. If it was true that claimant returned to work with no restrictions and continued to work from 1996 until May 2005, with no changes in the way he did things or in the way he conducted his lifestyle, Dr. Murati opined he would have no impairment rating for the preexisting injury.

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[3] Stein Depo. at 32.

Dr. Murati testified that he had assumed that claimant had absent ankle reflexes before his May 18, 2005, injury because the ankle reflex was missing when he examined him on February 21, 2007. After being shown records of Dr. Tomecek that indicated that claimant's reflexes were trace bilaterally and symmetric and being told that Dr. Tomecek testified that meant that claimant had ankle reflexes, Dr. Murati concluded that claimant did, in fact, have an ankle reflex on the right that predated the 2005 injury, which would work against any assumption of preexisting impairment.

Since claimant did have an ankle reflex on the right before his work-related injury and since Dr. Murati found that claimant had no atrophy, he opined that claimant would not have been in the DRE Category III before that injury. The highest impairment Dr. Murati could give claimant as a result of the 1996 injury if there was no radiculopathy is 5 percent, if he could prove there was preexisting impairment based on a sprain. But then he would have to see whether claimant actually had an injury that would be consistent with a sprain and that it was producing impairment, because not all injuries produce impairment.

Given that Dr. Murati did not have records of continuing complaints before May 18, 2005, and because he did not have any records from the 1996 surgery, he stated he cannot, within a reasonable degree of medical probability, determine whether claimant had a preexisting impairment.

Dr. Murati admitted that he had never given anyone a zero impairment rating who had actually had disc removal surgery. He stated, however, that impairment is defined in the AMA *Guides* as a medical condition that affects one's daily living. If claimant went back from his first surgery to working, had no issues with restrictions, and did not have to use pain medication, he could assume that claimant had no preexisting impairment. From the standpoint of the AMA *Guides*, he believed claimant did not have an impairment based on radiculopathy at least until after the July 2006 incident.

Although claimant still has a dull, aching pain most of the time, he believes he is functional. He takes two Aleve every morning before he leaves his house. His back gets tired and tight at the end of the day. He occasionally has pain in his right buttocks and right leg with numbness and tingling and has hip pain if he gets in the wrong position. He does not take any prescription medication for his low back condition. He currently works as a deputy for the Elk County Sheriff's Department.

PRINCIPLES OF LAW

K.S.A. 2006 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends."

K.S.A. 2006 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

The burden of proof is upon the claimant to establish his right to an award for compensation by proving all the various conditions on which his right to a recovery depends. This must be established by a preponderance of the credible evidence.[4]

The Workers Compensation Act provides that compensation awards should be reduced by the amount of preexisting functional impairment when the injury is an aggravation of a preexisting condition. The Act reads:

> The employee shall not be entitled to recover for the aggravation of a preexisting condition, except to the extent that the work-related injury causes increased disability. Any award of compensation shall be reduced by the amount of functional impairment determined to be preexisting.[5]

The Board interprets the above statute to require that a ratable functional impairment must preexist the work-related accident. The statute does not require that the functional impairment was actually rated or that the individual was given formal medical restrictions. But it is critical that the preexisting condition actually constituted an impairment in that it somehow limited the individual's abilities or activities. An unknown, asymptomatic condition that is neither disabling nor ratable under the AMA *Guides* cannot serve as a basis to reduce an award under the above statute.

A physician may appropriately assign a functional impairment rating for a preexisting condition that had not been rated. However, the physician should use the claimant's contemporaneous medical records regarding the prior condition. The medical condition diagnosed in those records and the evidence of the claimant's subsequent activities and treatment must then be the basis of the impairment rating using the appropriate edition of the AMA *Guides*.

In *Logsdon*,[6] the Kansas Court of Appeals stated:

> Whether an injury is a natural and probable result of previous injuries is generally a fact question.

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[4] *Box v. Cessna Aircraft Company*, 236 Kan. 237, 689 P.2d 871 (1984).

[5] K.S.A. 2006 Supp. 44-501(c).

[6] *Logsdon v. Boeing Co.*, 35 Kan. App. 2d 79, Syl. ¶¶ 1, 2, 3, 128 P.3d 430 (2006).

> When a primary injury under the Workers's Compensation Act is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury, including a new and distinct injury, is compensable if it is a direct and natural result of a primary injury.
>
> When a claimant's prior injury has never fully healed, subsequent aggravation of that same injury, even when caused by an unrelated accident or trauma, may be a natural consequence of the original injury, entitling the claimant to postaward medical benefits.

In general, the question of whether the worsening of a claimant's preexisting condition is compensable as a new, separate and distinct accidental injury under workers compensation turns on whether his or her subsequent work activity aggravated, accelerated, or intensified the underlying disease or affliction.[7] However, every direct and natural consequence that flows from a compensable injury, including a new and distinct injury, is also compensable under the Workers Compensation Act. In *Jackson*[8], the court held:

> When a primary injury under the Workmen's Compensation Act is shown to have arisen out of the course of employment every natural consequence that flows from the injury, including a new and distinct injury, is compensable if it is a direct and natural result of a primary injury.

But the *Jackson* rule does not apply to new and separate accidental injuries. In *Stockman*[9], the court attempted to clarify the rule:

> The rule in *Jackson* is limited to the results of one accidental injury. The rule was not intended to apply to a new and separate accidental injury such as occurred in the instant case. The rule in *Jackson* would apply to a situation where a claimant's disability gradually increased from a primary accidental injury, but not when the increased disability resulted from a new and separate accident.

In *Stockman*, claimant suffered a compensable back injury while at work. The day after being released to return to work, the claimant injured his back while moving a tire at home. The *Stockman* court found this to be a new and separate accident.

In *Gillig*[10], the claimant injured his knee in January 1973. There was no dispute that the original injury was compensable under the Workers Compensation Act. In March 1975,

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[7] *See Boutwell v. Domino's Pizza*, 25 Kan. App. 2d 110, 959 P.2d 469, *rev. denied* 265 Kan. 884 (1998).

[8] *Jackson v. Stevens Well Service*, 208 Kan. 637, Syl. ¶ 1, 493 P.2d 264 (1972).

[9] *Stockman v. Goodyear Tire & Rubber Co.*, 211 Kan. 260, 263, 505 P.2d 697 (1973).

[10] *Gillig v. Cities Service Gas Co.*, 222 Kan. 369, 564 P.2d 548 (1977).

while working on his farm, the claimant twisted his knee as he stepped down from a tractor. Later, while watching television, the claimant's knee locked up on him. He underwent an additional surgery. The district court in *Gillig* found that the original injury was responsible for the surgery in 1975. This holding was upheld by the Kansas Supreme Court.

In *Graber*[11], the Kansas Court of Appeals was asked to reconcile *Gillig* and *Stockman*. It did so by noting that *Gillig* involved a torn knee cartilage which had never properly healed. *Stockman*, on the other hand, involved a distinct reinjury of a back sprain that had subsided. The court, in *Graber*, found that its claimant had suffered a new injury, which was "a distinct trauma-inducing event out of the ordinary pattern of life and not a mere aggravation of a weakened back."[12]

ANALYSIS

Claimant suffered a work-related low back injury on May 18, 2005. His subsequent aggravation or exacerbation of symptoms on July 9, 2006, was at the same level and same side as in 2005 and was a natural progression of his earlier work-related injury. It is compensable as a direct consequence of that injury. It did not result from a subsequent accident and did not constitute a new and distinct intervening injury. Also, it was not a direct and natural consequence of his 1996 injury.

It is more probably true than not true that claimant had radiculopathy when he underwent low back surgery in 1996. Although none of the physicians were provided with claimant's records from the 1996 surgery, the MRI scan performed on May 24, 2005, showed postoperative changes at L5-S1 on the right side of the disc. According to Dr. Stein, claimant met the criteria for a DRE III 10 percent impairment before his injury of May 18, 2005. Dr. Stein places claimant in that same DRE III category now. However, claimant has now been diagnosed with loss of segment integrity. Dr. Tomecek's records support this new diagnosis, as does his recommendation that any surgery include a spinal fusion at L5-S1. This supports Dr. Murati's opinion that claimant's condition is now in the DRE V category. Subtracting the 10 percent preexisting impairment from the current 25 percent impairment, using the combined values chart in the AMA *Guides*, results in a net 17 percent impairment.

CONCLUSION

Claimant's total impairment is 25 percent under the 4th edition of the AMA *Guides*. Claimant's preexisting impairment was 10 percent under the 4th edition of the AMA *Guides.* Respondent is entitled to a credit for the percentage of claimant's impairment that preexisted his May 18, 2005, work-related accident. The claimant's net impairment per the

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[11] *Graber v. Crossroads Cooperative Ass'n*, 7 Kan. App. 2d 726, 648 P.2d 265, *rev. denied* 231 Kan. 800 (1982).

[12] *Id*. at 728.

AMA *Guides,* for which he is entitled for permanent partial disability compensation, is 17 percent. Claimant did not suffer a subsequent intervening injury. Therefore, no portion of that 17 percent impairment is attributable to any subsequent injury, and respondent is liable for all of claimant's medical treatment, including the surgery in July 2006.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Nelsonna Potts Barnes dated December 7, 2007, is modified to find claimant is entitled to an award of permanent partial disability compensation based upon a 17 percent permanent impairment of function, but is otherwise affirmed.

Claimant is entitled to 19.54 weeks of temporary total disability compensation at the rate of $437.51 per week or $8,548.95, followed by 69.78 weeks of permanent partial disability compensation at the rate of $437.51 per week or $30,529.45, for a 17 percent functional disability, making a total award of $39,078.40.

As of March 7, 2008, there would be due and owing to the claimant 19.54 weeks of temporary total disability compensation at the rate of $437.51 per week in the sum of $8,548.95 plus 69.78 weeks of permanent partial disability compensation at the rate of $437.51 per week in the sum of $30,529.45, for a total due and owing of $39,078.40, which is ordered paid in one lump sum less amounts previously paid.

IT IS SO ORDERED.

Dated this _____ day of March, 2008.

_____
BOARD MEMBER

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BOARD MEMBER

_____
BOARD MEMBER

c: Orvel Mason, Attorney for Claimant
Jeffery R. Brewer, Attorney for Respondent and its Insurance Carrier
Nelsonna Potts Barnes, Administrative Law Judge